PRINTED: 10/03/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G151	A. BUILDING _____ B. WING _____	09/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 08	1600 FRANKLIN STREET, NE WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from September 17, 2008 through September 19, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients were selected from a population of four females with various disabilities. The findings of this survey were based on observations at the group home and one day program, interviews at both the group home and day program and review of clinical and administrative including the facility's unusual incident and investigation reports.	W 000	Received 10/15/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the facility failed to demonstrate how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States for 4 of 4 clients residing in the facility. The finding includes: The facility failed to ensure clients' rights were protected by making certain each client had a	W 125		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Martha Thomas	Vice President	10/14/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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WHOLISTIC 08	1690 FRANKLIN STREET, NE WASHINGTON, DC 20017

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W 125	Continued From page 1 legally sanctioned representative to assist them with making decisions residential placement as evidenced below: During the survey conducted from September 17-19, 2008, a door alarm was noted to sound each time the exterior door to the facility opened. Interview with the Qualified Mental Retardation Professional (QMRP) on September 19, 2008 at approximately 2:45 PM revealed the purpose of the door alarm was to address Client #4's target behavior of elopement. The QMRP further stated that the use of the door alarm had been approved by the Human Rights Committee (HRC). Review of the HRC minutes dated May 8, 2008 on September 19, 2008 at 2:35 PM confirmed the QMRP's statement. Continued interview with the QMRP revealed that Client #4's housemates were informed of the and they all approved either by verbal response and/or by implication. The QMRP further revealed that Client #4's housemates legal guardians and/or involved family members were not involved in the decision making process regarding the door alarm. Review of Client #4's housemates psychology assessments indicated that they did not evidence the capacity to make independent decisions on their behalf regarding habilitation planning, placement, treatment, financial or medical matters.	W 125	Qmrp shall inform in writing the use of the Alarm. Gaurdians will be given an opportunity to articulate concerns and any opposition shall be taken through the HRC for a dignity vs. Risk analysis.	10/16/08
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159		

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WHOLISTIC 09	1800 FRANKLIN STREET, NE WASHINGTON, DC 20017

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W 159	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States. [See W125] 2. The QMRP failed to ensure that fire evaluation drills were conducted quarterly on all shifts. [See 440]	W 159	See W125 See 440	
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide routine laboratory testing as determined necessary by the physician for one of two clients included in the sample. (Client #1) The finding includes: On September 17, 2008 at 6:49 PM, Client #1	W 325		

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W 325	Continued From page 3 was administered Lithium Carbonate 300 mg by mouth. Interview with the Trained Medication Employee (TME) revealed that the medication was prescribed for maladaptive behaviors. Review of Client #1's Physician's Orders (POS) dated September 2008 on September 18, 2008 at 1:18 PM revealed an order for the client to receive Lithium levels every 2-3 months. Review of the laboratory tests on September 18, 2008 at approximately 1:18 PM revealed Client #1 received labs in July 2008, May 2008, and December 2007. Further record review and interview with the facility's Licensed Practical Nurse Coordinator (LPN) on the same day at 1:55 PM acknowledged that Client # 1's Lithium levels were not obtained as recommended by the physician.	W 325	RN will ensure that all Labs are secured as prescribed in POS. [redacted] Nurse's monthlies shall address Labs and whether or not they have been attained. Quarterly RN notes shall review monthly notes to ensure completion of Labs as required	10/16/08
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility's nursing services failed to ensure that each client received nursing services in accordance with their needs for one of two clients included in the sample. (Client #1) The finding includes: The facility's nursing staff failed to ensure routine laboratory tests were obtained in accordance with physician's orders for Client #1. [See W325]	W 331	See W325	
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental	W 356		

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W 356	Continued From page 4 treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely dental services, for two of two clients included in the sample. (Client #1 and #2) The findings includes: 1. On September 17, 2008 during evening observations, Client #1 was observed with some discoloration on her teeth. Review of Client #1's medical records on September 18, 2008 at approximately 2:10 PM revealed a dental consult dated September 13, 2007. According to the consult, Client #1 was scheduled for dental treatment, but refused to get off the van and therefore, the appointment was rescheduled. Interview with the Licensed Practical Nurse (LPN) coordinator revealed that Client #1 had a dental appointment scheduled for October 6, 2008 over a year later. Interview with the facility's Registered Nurse (RN) on September 18, 2008 at approximately 2:19 PM revealed that Client #1 should have been scheduled for her six month dental treatment prior to the October 2008 appointment. There was no evidence that any other attempts to obtain dental services for Client #1 prior to October 2008. 2. On September 17, 2008 during evening observations, Client #2 was observed with plaque build up on her teeth. Review of Client #2's medical records on September 18, 2008 at	W 356	Dental services had been challenging to schedule. However, quite recently getting appointments have improved substantially. The October 6th appointment has been completed. In the future ANY delays in securing appointments shall be documented in the record. Last all recommendations shall be transcribed in the Nurses monthly and implementation noted in the record.	10/16/08

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W 356	Continued From page 5 approximately 3:15 AM revealed a dental consul dated July 30, 2007. According to the consultant's notes, the client had advanced periodontal disease and deposits of plaque calculus on all teeth surfaces. The dentist recommended that Client #2 return to the office for full mouth scaling and polishing of all teeth surfaces in six months. Interview with the LPN coordinator on September 18, 2008 at approximately 3:36 PM revealed that Client #2 had a scheduled dental appointment on September 24, 2008 (over a year later). At the time of the survey, the facility failed to provide evidence that Client #2 received timely dental services.	W 356		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, staff interview and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for two of two clients included in the sample. (Client #1 and #2) The findings include: 1. On September 17, 2008 at 6:49 PM, Client #1 was administered Lithium Carbonate 300 mg and Chlorpromazine HCL 50 mg by mouth by the Trained Medication Employee (TME) during the	W 371		

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W 371	Continued From page 6 evening medication administration. Client #1 was observed to retrieve a cup from the dishwasher and poured water into the cup. Further observations revealed the TME punched medications into the pill cup and explained the medications to Client #1. Client #1 independently consumed her medications and placed the cup back into the kitchen sink. Interview with the facility's Registered Nurse (RN) on September 19, 2008, at approximately 2:00 PM revealed that Client #1 had a self-medication assessment dated June 18, 2008, but did not have a self-medication program established. Review of the self-medication assessment on September 18, 2008, revealed Client #1 was recommended to participate in a self-medication program. There was no evidence that a program had been identified/established for Client #1 in the domain self-medication administration. 2. On September 17, 2008, at 7:00 PM, Client #2 was administered Amantadine HCL 100 mg and Gabapentin 300 mg by mouth by the TME during the evening medication administration. The TME explained to Client #2 what she was taking, punched medications into the medication cup, and poured water in the cup. Client #2 was observed to drink her cup water as she consumed the medications. Interview with the facility's Registered Nurse (RN) on September 19, 2008, at approximately 2:00 PM revealed that Client #2 had a self-medication assessment but did not have a self-medication programs established. Review of the self-medication assessment dated June 12, 2008, and further interview with the RN revealed that Client #2 was recommended to participate in a	W 371	Self-medication program for Client #1 is in place. Self-Medication program for Client #2 is in place.	10/16/08 10/16/08

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W 371	Continued From page 7 self-medication program. There was no evidence that a program had been identified/established for Client #2 in the domain self-medication administration.	W 371		
W 440	483.470(l)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on September 18, 2008 at 11:56 AM revealed the scheduled shifts were as follows: Weekdays/Weekends 1st Shift 8 AM to 4 PM 2nd Shift 4 PM to 12 AM 3rd Shift 12 AM to 8 PM Further interview with the QMRP revealed that the staff were required to conduct a drill quarterly during each shift. Review of the fire drill log from August 2007 through August 2008 on September 18, 2008 at 11:56 AM revealed that the facility failed to hold fire evacuation drills quarterly during the first shift. Continued interview with the QMRP acknowledged that fire drills had not been conducted during each shift. There was no evidence that fire drills were conducted quarterly	W 440	Staff will be retrained on fire drill schedule and their role in its implementation. Provider has issued reprimand to House Manager for failure to implement the regulations as she has been trained multiple times. This is the last time this facility will recieve this citation!	10/16/08

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W 440	Continued From page 8 on all shifts. This is a repeated, uncorrected deficiency. See deficiency report dated August 22, 2007.	W 440		

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WHOLISTIC 08	1600 FRANKLIN STREET, NE WASHINGTON, DC 20017

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R 000	INITIAL COMMENTS A licensure survey was conducted from September 17, 2008 through September 19, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients were selected from a population of four females with various disabilities. The findings of this survey were based on observations at the group home, one day program, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident and investigation reports.	R 000	Received 10/15/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the interview and review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the personnel files on September 19, 2008 at 12:32 PM revealed the GHMRP failed to provide evidence of a criminal background checks that disclosed a seven year listing of all jurisdictions where five (5) staff	R 125	some of The five staff that are in question are employees that have been with wholistic prior to the implementation of this requirement. Wholistic has implemented this prospectively. The remaining were completed but not in the file at the facility. All staff	10/14/08

Health Regulation Administration

Martha Thomas — Vice President — 10/14/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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R 125	Continued From page 1 persons had worked or resided at the time of the survey.	R 125	have or will have the seven year, every place they have worked or lived by the 17th of october.	10/17/08

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I 000	INITIAL COMMENTS A licensure survey was conducted from September 17, 2008 through September 19, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients were selected from a population of four females with various disabilities. The findings of this survey were based on observations at the group home, one day program, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident and investigation reports.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure blinds and curtains at each window. The findings include: Observation of the environment conducted on September 19, 2008 revealed that the blinds throughout the facility was observed to be damaged. Interview with the House Manager and Qualified Mental Retardation Professional (QMRP) on September 19, 2008 at approximately 2:50 PM acknowledged that blinds needed to be replaced through the facility.	I 022	All blinds have been replaced by roller shades throughout the facility.	10/1/08
I 135	3505.5 FIRE SAFETY	I 135		

Health Regulation Administration

M. Latta Thomas — Vice President — 10/14/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 135	Continued From page 1 Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on September 18, 2008 at 11:56 AM revealed the scheduled shifts were as follows: Weekdays/Weekends 1st Shift 8 AM to 4 PM 2nd Shift 4 PM to 12 AM 3rd Shift 12 AM to 8 PM Further interview with the QMRP revealed that the staff were required to conduct a drill quarterly during each shift. Review of the fire drill log from August 2007 through August 2008 on September 18, 2008 at 11:56 AM revealed that the facility failed to hold fire evacuation drills quarterly during the first shift. Continued interview with the QMRP acknowledged that fire drills had not been conducted during each shift. There was no evidence that fire drills were conducted quarterly on all shifts. This is a repeated, uncorrected deficiency. See deficiency report dated August 22, 2007.	I 135	See W 159 W 440	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 206	Continued From page 2	I 206		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file. The finding includes: Interview with the Qualifed Mental Retardation Professional and review of the personnel files conducted on September 19, 2008 at 12:32 PM revealed the GHMRP failed to provide evidence of current health certificates for one consultant at the time of the survey.	I 206	All consultants currently have an updated physical.	10/14/08
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.	I 379		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0172	A. BUILDING _____ B. WING _____	09/18/2008

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I 379	Continued From page 3 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that injuries of unknown origin are reported to the facility's administrator and government agencies as required by DC Regulation. [22 DCMR Chapter 35 Section 3919.10] The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports, including available corresponding investigative reports, on September 18, 2008 at 11:31 AM revealed the following: On May 29, 2008, 911 personnel was called to transport Resident #4 to CEPAP who at the time was exhibiting maladaptive behaviors that could potentially cause harm to herself and others. Continued review of the facility's incidents failed to provide evidence that the incident was reported to the Department of Health as required.	I 379	New Incident reporting measures have been put in place by provider pursuant to survey at 7533 12th Street - Location in ~~By~~ August. DOH shall be notified by Main office about all incident reports. This shall be followed up by a phone call to ensure reciept.	10/1/08
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to provide routine laboratory testing as determined necessary by	I 401		

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I 401	Continued From page 4 the physician for one of two residents included in the sample. (Resident #1) The finding includes: On September 17, 2008 at 6:49 PM, Resident #1 was administered Lithium Carbonate 300 mg by mouth. Interview with the Trained Medication Employee (TME) revealed that the medication was prescribed for maladaptive behaviors. Review of Resident #1's Physician's Orders (POS) dated September 2008 on September 18, 2008 at 1:18 PM revealed an order for the client to receive Lithium levels every 2-3 months. Further record review and interview with the facility's Licensed Practical Nurse Coordinator (LPN) on the same day at 1:55 PM acknowledged that Resident # 1's Lithium levels were not obtained as recommended by the physician.	I 401	W325	
I 472	3522.3 MEDICATIONS The physician who identifies the self-administration of medications as a goal for a resident shall develop and monitor the plan for implementation. This Statute is not met as evidenced by: Based on observations, interviews, and record review, the GHMRP failed to ensure the implementation of self-medication programs for residents. The finding includes: See Federal Deficiency Report Citation W371	I 472	See W371	
I 500	3523.1 RESIDENT'S RIGHTS	I 600		

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I 500	Continued From page 6 Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the facility failed to demonstrate how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States for 4 of 4 clients residing in the facility. The finding includes: The facility failed to ensure clients' rights were protected by making certain each client had a legally sanctioned representative to assist them with making decisions residential placement as evidenced below: During the survey conducted from September 17-19, 2008, a door alarm was noted to sound each time the exterior door to the facility opened. Interview with the Qualified Mental Retardation Professional (QMRP) on September 19, 2008 at approximately 2:45 PM revealed the purpose of the door alarm was to address Client #4's target behavior of elopement. The QMRP further stated that the use of the door alarm had been approved by the Human Rights Committee (HRC). Review of the HRC minutes dated May 8, 2008 on September 19, 2008 at 2:35 PM confirmed the QMRP's statement. Continued interview with the QMRP revealed that	I 500	See W125	10/16/08

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I 500	Continued From page 6 Client #4's housemates were informed of the and they all approved either by verbal response and/or by implication. The QMRP further revealed that Client #4's housemates legal guardians and/or involved family members were not involved in the decision making process regarding the door alarm. Review of Client #4's housemates psychology assessments indicated that they did not evidence the capacity to make independent decisions on their behalf regarding habilitation planning, placement, treatment, financial or medical matters.	I 500		